Friendship Baptist Association
Christmas Backpacks Mission Trip

Personal Data (please print or type)

Legal Name _____

Address_____

_____

Please Indicate The Best Way To Reach You

Email Address _____ Cell Phone ( ) _____

Home Phone ( ) _____ Work Phone ( ) _____

Emergency Contact Person:

Name and address _____

_____

_____

Phone Number ( ) _____ Alternate Number ( ) _____

Relationship _____Parent _____ Spouse _____Other (specify) _____

Health Insurance: _____Yes _____No

Personal History
Have you ever been on a mission trip before? ____Yes ____No

Briefly Describe

Do you have a personal relationship with Christ? ____Yes ____No

Church Membership _____

Health
My health is _____excellent _____good _____fair _____poor

To Register: Please submit this form and $50 fee to the FBA office before November 15, 2015.

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ADULT PARTICIPANTS

RELEASE, HOLD HARMLESS AND INDEMNITY

I, the undersigned, acknowledge that participating in the Friendship Baptist Association Mission Trip to Tennessee (the "Mission Trip") involves certain risks and that injury, death or other harm (including damage to property) could occur to me ("Injuries"). By participating in the Mission Trip, I hereby assume full responsibility for the risk of Injuries, whether caused by negligence or otherwise. I, on my own behalf and on behalf of my heirs, successors, assigns, executors and administrators, hereby RELEASE AND HOLD HARMLESS AND AGREE TO INDEMNIFY Friendship Baptist Association and its staff, volunteer leaders, members, employees (hereinafter collectively referred to as "FBA") from and against any and all liability, claims, damages, causes of action, loss, costs and expenses (including, without limitation, attorney fees) for Injuries arising out of or connected with the Mission Trip, including traveling to and from the location(s) of the Mission Trip.

MEDICAL AUTHORIZATION
If, while participating in the Mission Trip, I require emergency medical treatment, I hereby give my consent for any emergency medical care to be rendered as may be deemed necessary by any duly licensed physician or dentist. I hereby give my permission to FBA to obtain the emergency medical treatment at any hospital, clinic or other health care provider as may be deemed appropriate. In these circumstances, I hereby request and authorize any duly licenses physicians, dentists and staff, or other licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatment as may be necessary, including but not limited to medical transport, hospital tests, injections, anesthesia, surgery and administration of prescription drugs. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes from any Medical Contacts provided by FBA. I agree to assume and pay for all costs of such emergency medical treatment.

Signature of Participant: _____ Date: _____

Printed Name: _____

Witness Signature: _____ Date: _____

Printed Name:_____

WITHOUT THIS FORM WITH YOU AND SIGNED
YOU WILL NOT BE ALLOWED TO PARTICIPATE

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